

YMCA Camp Seymour Camper Release Form

This document identifies people who are authorized to pick-up and/or be contacted regarding the below-named child. Persons listed on this form are understood to be contacts for camp to use while the camper is in the care of camp, and able to be contacted to pick-up the camper as needed (due to behavior, illness, or at the end of the session). The person dropping off/picking up the child must sign this form at camp, and a camp staff member must witness the signature. Only authorized adults listed on this sheet may pick up children from camp. Photo identification will be required at pick up, for your child's safety. Please notify Camp Seymour if there are any changes (253) 884-3392.

Camper's Name _____
Last First Middle Initial

Registered Session: _____
(if the camper is attending more than one session please complete an additional release form per session)

Camper lives with (circle one):
Mother Father Both: together Both: separately Other: _____

I authorize the following adults to pick-up my camper from camp as necessary should he/she need to leave camp early due to illness, injury, or behavior, and at the end of the session. I have informed them that they are listed here and might be contacted.

Camp Seymour will only release campers to adults listed here regardless of their relationship to the camper, or being listed on another form. **Therefore, please make sure to list all appropriate guardians, parents, relatives, and friends.** Please be attentive to when your camper's session ends and have an adult listed here scheduled to pick him/her up.

Parent/Guardian

<u>Name</u>	<u>Day Phone</u>	<u>Cell/Evening phone</u>
_____	_____	_____
_____	_____	_____

Additional Contacts (please list at least one)

<u>Name</u>	<u>Relationship to camper</u>	<u>Day Phone</u>	<u>Cell/Evening phone</u>
_____	_____	_____	_____
_____	_____	_____	_____

The above-listed people have my permission to pick-up my child from YMCA Camp Seymour.

I hereby give permission to YMCA Camp Seymour to provide or arrange any necessary program-related transportation for my child (e.g. specialty camp day-trip transportation, low tide boating accommodations, Adventure Camp trip transportation). Most likely this would be in a mini-bus driven by a YMCA Camp Seymour staff member or volunteer. All drivers complete a driving safety course and vehicle orientation.

Parent/Guardian Signature _____

Please print name _____ **Date** _____

SESSION	BUS
<input type="checkbox"/> Week 1	
<input type="checkbox"/> Week 2	HFY
<input type="checkbox"/> Week 3	
<input type="checkbox"/> Week 4	Bravo Terr
<input type="checkbox"/> Week 5	
<input type="checkbox"/> Week 6	TTFY
<input type="checkbox"/> Week 7	
<input type="checkbox"/> Week 8	MFY

YMCA Camp Seymour Health & Medical History Form

- ✓ *The information on this form helps us provide the best care for your child; withholding, misrepresenting, or incomplete information may be grounds for dismissal. Notify camp staff if there are changes to this form.*
- ✓ *A **medical exam** is required only if the camper has had surgery, serious illness, injury that has limited his/her activity, or has been hospitalized in the past year.*
- ✓ *All medications (prescription, over-the-counter, & supplements) brought to camp must be listed on this form and in their original container.*
- ✓ *This form is for Health Center use; information important for your child's cabin leader to know should be repeated on the "Letter to my Child's Leader."*

SESSION	BUS
<input type="checkbox"/> Week 1	
<input type="checkbox"/> Week 2	HFY
<input type="checkbox"/> Week 3	
<input type="checkbox"/> Week 4	Bravo Terr
<input type="checkbox"/> Week 5	
<input type="checkbox"/> Week 6	TTFY
<input type="checkbox"/> Week 7	
<input type="checkbox"/> Week 8	MFY

Camper Name _____
Last First Middle Initial

Home Address _____
City _____ **State** _____ **Zip** _____

Home Phone () _____ **Gender** M F **Birthdate** _____

Age at start of camp _____ **Grade entering in the fall** _____

Camper lives with (circle one): Mother / Father / Both: together / Both: separately / Other: _____

1st Parent's/Guardian's Name _____
 Home Phone _____ Work Phone _____ Cell Phone _____

2nd Parent's/Guardian's Name _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Home Address (if different from above) _____
 City _____ State _____ Zip _____

Additional Contacts - *If the above are unreachable these will be contacted in case of camper illness/behavior*

1. Name _____ Relationship to camper: _____
 Home Phone _____ Work Phone _____ Cell Phone _____
2. Name _____ Relationship to camper: _____
 Home Phone _____ Work Phone _____ Cell Phone _____

Insurance Information - Is the participant covered by family medical/hospital insurance? Yes No
 Carrier/plan name _____ Group # _____
 Carrier Address _____
 Name of Insured _____ Relationship to Participant _____
 Insurance ID number _____

Medical treatment at Camp Seymour

The following over-the-counter medications are used at camp under the recommendation of Camp Seymour's overseeing physician and the seasonal Health Care Director. Feel free to cross out any products that you do NOT want your child to have.

I give permission for the following medications to be administered for common ailments:

- | | | | | |
|---------|--------------------------|-------------|-----------------|-------------------------|
| Tums | Claratin | Advil | Bee sting swabs | 1% hydrocortisone cream |
| Tylenol | Liquid cough suppressant | Cough drops | Aloe Vera gel | Benadryl, 25mg & cream |
| Anbesol | Sudafed decongestant | Sunscreen | Pepto-Bismol | Antibiotic cream |

Authorization to Provide Necessary Treatment or Emergency Care

I hereby give permission to medical personnel selected by the camp director to order x-rays, routine tests, or other treatment; to release any records necessary for insurance purposes; to release a diagnosis and prescription to camp staff; and to provide or arrange any necessary related transportation for my child. If I cannot be contacted, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization. This completed form may be photocopied for trips out of camp. Both side of this form are correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted on this form.

Parent/Guardian's Signature* _____

*If for religious reasons you cannot sign, contact camp for a waiver that must be signed for attendance. (Please complete both sides of this form)

Please Print Name _____ **Date** _____

Health History

Has/does the participant:

	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints(e.g. knees, ankles)?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems? (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, eyewear? ...	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	27. Have an eating disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?.....	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?...	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	29. Have ADD or ADHD?.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	30. Had a physical exam in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	31. Traveled abroad in the past month?....	<input type="checkbox"/>	<input type="checkbox"/>
16. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>			

Explain any "yes" answers, noting the number of the questions.

Allergies (Medication, Food, Other) Reaction and management of the reaction

Please provide additional information about the participant, such as their general behavior; physical, emotional, or mental health; significant life event that might affect behavior; and dietary or other restrictions.

Immunizations Give month & year of the last immunization/booster, or attach a copy of official record:
 _____ Tetanus _____ Measles/Mumps/Rubella _____ Hepatitis A _____ Diphtheria/Pertussis (DtaP/DT)
 _____ Chicken Pox _____ Meningitis _____ Hepatitis B _____ Other/specify:

Medications

Identify medications taken during school year that participant is not taking at YMCA Camp Seymour:

List all medications brought to camp. Attach additional paper as necessary. Keep medications in original packaging; prescription original packaging must identify the prescribing physician, medication name, dosage, and frequency of administration. Please call in advance if medications or dosage have changed in the past 3 months.

- This person takes medications as follows: This person takes NO routine medications.

Med. #1 _____ Reason for taking _____ Side effects: _____
 Time _____ Dosage _____ Time _____ Dosage _____
 Time _____ Dosage _____ Time _____ Dosage _____

Med. #2 _____ Reason for taking _____ Side effects: _____
 Time _____ Dosage _____ Time _____ Dosage _____
 Time _____ Dosage _____ Time _____ Dosage _____

Med. #3 _____ Reason for taking _____ Side effects: _____
 Time _____ Dosage _____ Time _____ Dosage _____

Family physician's name _____ Phone _____
Family dentist/orthodontist's name _____ Phone _____

YMCA Camp Seymour Participation Agreement YMCA OF PIERCE AND KITSAP COUNTIES



PLEASE PRINT LEGIBLY AND COMPLETE ALL NON-SHADED AREAS OF THIS FORM

PARTICIPANT INFORMATION		
FULL NAME	AGE	BIRTH DATE M M / D D / Y Y Y Y
ADDRESS		PHONE
NOTIFICATION OF RISKS		
<p>YMCA Camp Seymour program areas may include, but are not limited to, challenge course, climbing tower, sports and games, archery, arts and crafts, touch tanks, beach walks, hiking/nature activities, contact with live animals, transportation to/from off-site program locations, and evening programs such as campfires. Our program areas are designed to meet a wide range of physical abilities and we make reasonable accommodations to serve a diverse population. Activities may include sitting, walking, running, jumping, throwing, use of archery equipment (bows and arrows), contact with natural elements (sticks, shells, logs, trees, etc.), and craft supplies (paint, glue, dye, and potentially hot liquids such as wax or glue). When utilizing the challenge course, activities may also include participating in group initiatives on low (2 to 3 feet off of the ground) and high (25 to 40 feet off the ground) elements, and climbing and traversing on cables, logs, and ropes while attached to a belay (rope) system.</p> <p>As a participant, you are the best judge of your physical abilities and that of your dependent children. There is a significant element of risk involved in any adventure, sport, or activity associated with the outdoors. If you or your dependent children have a health condition, chronic illness, or injury that might be aggravated by doing these activities, you should not participate in these activities without first consulting a physician. Participation in camp activities is voluntary and participants may choose their level of involvement in all activities. In agreeing to participate, you assume all liability for any physical injuries and/or emotional distress suffered by you and/or your dependent children.</p>		
WAIVER AND RELEASE OF LIABILITY		
<p>I am aware that participation in YMCA programs and use of YMCA facilities may involve certain hazards associated with equipment, physical exertion, games, sports, and other programs/activities offered by the YMCA. In consideration of, and as part payment for, the right to use YMCA facilities and participate in YMCA programs, I hold harmless, waive, and release the YMCA ("YMCA" includes its employees, volunteers, directors, officers, and agents) for damages of any type, including permanent physical injuries or death, arising out of the ordinary negligence of the YMCA and also for damages of any type arising out of my own negligence, in whole or in part.</p> <p>By participating in the YMCA Nationwide Membership program, I agree to release the National Council of Young Men's Christian Associations of the United States of America, and its independent and autonomous member associations in the United States and Puerto Rico, from claims of negligence for bodily injury or death in connection with the use of YMCA facilities, and from any liability for other claims, including loss of property, to the fullest extent of the law.</p> <p>I assume all risk of injuries and damages associated with my participation in YMCA programs and the use of YMCA facilities including, but not limited to, falls, slips (whether occurring while in the building, offsite as a part of a program, or anywhere else on the YMCA facilities or property, including adjacent sidewalks, access, and parking areas), contact with other participants, sudden and unforeseen malfunctioning of any equipment, instruction, training, supervision, massage, therapy, classes, or dietary recommendations, the effects of the weather and/or temperature indoor or outdoor, and all other such risks being known and appreciated by me.</p> <p>This release includes foregoing any claim I may have for ordinary negligence arising out of my children's use of YMCA facilities or participation in YMCA programs. I understand that it is my responsibility to obtain a physician's release statement if my child has any physical or mental condition that may impair his or her ability to engage in any of the YMCA's programs or activities.</p> <p>I FULLY UNDERSTAND AND AGREE I AM WAIVING ALL CLAIMS I MAY HAVE AGAINST THE YMCA ARISING OUT OF THE ORDINARY NEGLIGENT ACTS BY THE YMCA, AND I AGREE I WILL NOT BRING A LAWSUIT AGAINST THE YMCA ARISING OUT OF ITS ORDINARY NEGLIGENCE. IF ANY PORTION OF THIS RELEASE IS HELD INVALID, I AGREE THE REMAINDER SHALL CONTINUE TO BE ENFORCEABLE.</p>		
PARTICIPANT SIGNATURE		DATE M M / D D / Y Y Y Y
PARENT/GUARDIAN SIGNATURE (IF UNDER AGE 18)		DATE M M / D D / Y Y Y Y